Medicaid Information Bulletin

January 2004

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Medicaid Information

- **Salt Lake City area, call 538-6155.**
- **In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.**
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04 - 01 Health Common Procedure Coding System - 2004 Revisions

Effective for dates of services on or after January 1, 2004, Medicaid begins accepting the 2004 version of the Health Common Procedure Coding System (HCPCS). HCPCS codes include the 2004 Physicians' Current Procedural Terminology (CPT) codes. You must continue to obtain prior authorization required for procedures on the 2003 list, even though new codes may be added for the same or similar procedures, or codes may be changed on the 2004 list.

This Medicaid Information Bulletin contains details about coding changes for services by physicians, medical suppliers and other provider types. Any 2003 HCPCS codes discontinued in 2004 may be used for dates of services prior to February 1, 2004. For services on and after February 1, 2004, providers must use the 2004 HCPCS codes. If you have a question concerning billing the 2004 HCPCS codes, please contact Medicaid Information. ☐

04 - 02 Chiropractic Services

All Chiropractic Services are provided through the Chiropractic Health Plan (CHP) provider network. Beginning February 1, 2004, there will be a $1 co-payment assessed on each visit for Traditional Medicaid clients. Remember that Non-Traditional clients already are assessed a $3 co-pay for chiropractic services and that the amount is limited to 16 aggregated visits annually in conjunction with physical therapy and occupational therapy. All services must be prior authorized through CHP. ☐

04 - 03 Dental-Oral Surgeon

Codes D5931, Surgical Obturator (Temporary) and D7670, Alveolus-stabilization of teeth, closed reduction have been revised for use only by the dentist at Primary Children's Hospital Cleft Palate Clinic. They are not open for general Medicaid by dentists or oral surgeons use.

CPT code 20670, Removal implant superficial; e.g. buried wire, screw, plate has been opened for use by oral surgeons. ☐

04 - 04 PT/OT/PT&OT in Rehab Centers

Q0086 is discontinued by HCPCS and is being replaced with T1015, Clinic visit/encounter, all inclusive. For OT services use T1015 with the GO modifier. The first ten visits do not require a prior authorization. All services beyond the first ten visits require prior authorization.

Please bill the T1015 on a HCFA 1500 form and additionally include the CPT codes for the actual services performed on the date of service as other line items on the form. Medicaid will pay on T1015 and use the CPT codes to record the services actually performed. Payment will be the same amount as Q0086. ☐

04 - 05 Vision

Code V02625, Enlargement of ocular prosthesis can be used to replace Y0363, Eye, artificial rebuilding.

Changed coding
V2117, lenticular lens, aspheric, single is discontinued and replaced with V2121, lenticular lens, per lens, single.
v2216, lenticular lens, aspheric, single is discontinued and replaced with V2221, lenticular lens, per lens, bifocal.

Beginning January 1, 2004, the additional following CPT codes are opened for medical services in **Traditional Medicaid**

and are open to optometrists and ophthalmologists. Please check the provider manual for prior authorization requirements and coverage restrictions including age limitations. These codes have been open to physicians and are now also open to optometrists. Codes:

65205	REMOVAL FOREIGN BDY EXTERNAL EYE
65210	REMOVAL FOREIGN BDY EMBEDDED CONJUNCTIV
65220	REMV FOR BDY SURFACE CORNEA W/SLIT LMP
65222	REMOV FOR BODY,SURFACE CORNEA,SLIP LAMP
67820	CORRECTION OF THRICHIASIS; EPILATION, FORCEPS ONLY
67850	DESTRUCTION LESION LED MARGIN,UP TO 1 CM
67938	REMOVAL OF EMBEDDED FOREIGN BODY, EYELID
68020	INCISION OF CONJUNCTIVE, DRAINAGE OF CYST
68761	CLOSURE OFTHE LACRIMAL PUNCTUM; BY PLUG, EACH
68801	DILATION OF LACRIMAL PUNCTUM, W,W/O IRRIGATION
68840	PROBING OF CANALICULI W/WO IRRIGATION
92020	GONIOSCOPY (SEPARATE PROCEDURE)
92060	SENSORIMOTOR EXAM,MULT MEAS OCULAR DEV,INTERP/RPRT
92070	FITTING CONTACT LENS,TREAT DISEASE;INCL LENS
92081	VISUAL FIELD EXAM,UNI/BILAT,MED DIAG EVAL;LTD EXA
92082	COLOR VISION EXAMINATION EXTENTED; E.G. ANOMALOGSCOPE
92083	VISUAL FIELD EXAM,UNI/BILAT,MED DIAG EVAL;EXTEND
92100	SERIAL TONOMETRY,MULTI MEAS PRESS,EXT TIME,INTERP
92120	TONOGRAPHY,INTERP,REPRT,RECORD TONOMETER/SUCTION
92135	SCAN COMPUTER OPHTHALMIC DIAG IMAG W INTER/REPORT
92136	OPHTHALMIC BIOMETRY PART COHERENCE INTERFEROMETRY
92225	OPHTHALMOSCOPY,EXT RETIN DRAW,INTERP,REPRT;INITIAL
92226	OPHTHALMOSCOPY,EXT AS FOR RETINAL DETACH,SUBSQUEN
92250	FUNDUS PHOTOGRAPHY WITH INTERPRETATION AND REPORT
92285	EXTERNAL OCULAR PHOTOGRAPH W INTERP,REPORT,PROGESS
92310	PRESCRIPTION OF OPTICAL, FITTING CONTACT LENSE, EXCEPT APHAKIA
92312	-PRESCRIP/FIT CONTACT LENSES,MED SUPER/APHAKIA,BOT
92325	MODIFICATION OF CONTACT LENS(SEPARATE PROCEDURE)-
92330	PRESCRIPTION,FITTING,SUPPLY OF OCULAR PROSTHESIS
92390	SUPPLY OF SPECTACLES,EXC PROSTHESIS/LOW VISION AID
92391	SUPPLY OF CONTACT LENSES,EXC PROSTH FOR APHAKIA
92392	SUPPLY OF LOW VISION AIDS (READING ADDS TO 4 D.)
92395	SUPPLY OF PERMANENT PROSTHESIS FOR APHAKIA,SPECTCL
95930	VISUAL EVOKED POTENTIAL TEST,CHECKERBOARD / FLASH
99204	OFFICE / OUTPAT VISIT NEW 3/3 H:CM E:CM D:MC
99205	OFFICE / OUTPAT VISIT NEW 3/3 H:CM E:CM D:HC
99214	OFFICE / OUTPAT VISIT ESTAB. 2/3 H:DT E:DT D:MC
99215	OFFICE / OUTPAT VISIT ESTAB. 2/3 H:CM E:CM D:HC
99241	OFFICE CONSULTATION NEW/EST 3/3 H:PF E:PF D:SF
99242	OFFICE CONSULTATION NEW/EST 3/3 H:EP E:EP D:SF
99243	OFFICE CONSULTATION NEW/EST 3/3 H:DT E:DT D:LC
99244	OFFICE CONSULTATION NEW/EST 3/3 H:CM E:CM D:MC
99245	OFFICE CONSULTATION NEW/EST 3/3 H:CM E:CM D:HC

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04 - 06 Speech Augmentative Communication Device Coding Changes

K0544, Speech generating device, synthesized, is replaced with E2502, Speech generating device, digitized speech, using pr-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time, and E2508, Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the

device, and E2510, Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access
K0546. Accessory for speech generating device, mount is replaced with E2512, Accessory for speech generating device, mounting system.
K0547, Accessory for speech generating device is discontinued. ☐

04 - 07 Medical Supplies

Photo Therapy

Photo therapy for bilirubin and jaundice, code E0202LL, is payable per day with a 7 day maximum for treatment. If treatment is extended beyond 7 days a prior authorization is required.

Diapers and Briefs

Beginning January 1, 2004, the following codes for briefs are opened requiring a prior authorization. These are priced at the same level as corresponding diapers. The aggregated limit is 156 units for either diapers, briefs, or a combination thereof. Briefs will require prior authorization.

A4525 Adult-Sized incontinence product, brief, small size, each
A4526 Adult-sized incontinence product, brief, medium size, each
A4527 Adult-sized incontinence product, brief, large size, each
A4528 Adult-sized incontinence product, brief, extra large, each
A4531 Child-sized incontinence product, brief, small/medium size, each
A4532 Child-sized incontinence product, brief, large size, each
A4334 Youth-sized incontinence product, brief, small/medium size, each

Wheelchair rental codes K0001LL to K0007LL

Wheelchair codes K0001LL to K0007LL can be billed with attachment E0990, elevating leg rest. This is the only attachment that can be billed the above wheelchair codes. All other attachments are not billable with these wheelchair rental codes.

Ventilator Codes

Additional Ventilator codes are opened. These will pay at the same rate as E0450, Volume Ventilator.
E0454, Pressure, ventilator with pressure control, pressure, support and flow triggering features.
E0461, Volume ventilator, stationary or portable with backup rate feature, used with non-invasive interface.

Added Codes

A5061 Pouch, drainable, with barrier attached
E0140 Walker, with trunk support, adjustable or fixed height, any type, Rental or Purchase, requires prior authorization.
K0591 Ostomy pouch, is replaced by A4428, Ostomy Pouch
E0300 Pediatric crib, hospital grade, fully enclosed, Rental or Purchase, requires prior authorization
E0955 Wheelchair accessory, headrest, cushioned, prefabricate, including fixed mounting hardware, each.
E0956 Wheelchair accessory, lateral trunk or hips support, prefabricated. (hip guides)
E0957 Wheelchair accessory, medial thigh support, prefabricated, including fixed mounting hardware. (abductor pads)
E0960 Wheelchair accessory, should harness/straps or chest strap, including any type mounting hardware.
E2325 Power wheelchair accessory, sip n and puff interface, non-proportional including all related electronics, mechanical stops with, and manual swing-a-way mounting hardware. Requires prior authorization.
E2327 Power wheelchair accessory, head control interface, mechanical, non-proportional including all related electronics, mechanical directional change switch, fixed mounting hardware. Requires prior authorization
E2328 Power wheelchair accessory, head control or extremity control interface, electronic, non-proportional including all related electronics, fixed mounting hardware. Requires prior authorization.
A4373 Ostomy skin, barrier, w flange convexity, any size
A4414 Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4x4 inches or smaller each
L0100 Cranial orthosis (Helmet), with or without soft interface, molded to patient model
L0400 TLSO, anterior-posterior-lateral control molded to patient model, with interface material

L2037 KAFO, full plastic, single upright, free, knee, custom- fabricated
L3260 Surgical boot/shoe, each
L4350 Pneumatic ankle foot orthosis, with or without joints, prefabricated, includes fitting and adjustment
L4386 Non-pneumatic walking splint, w/ w/o joint, prefabricated, includes fitting and adjustments
L5010 Partial foot, molded socket, ankle height, with toe filler
L5301 Below knee, molded socket, shin, sach foot, endoskeletal system
L6660 Upper extremity addition, heavy duty control cable

Cross walks

Y6045, prone stander is replaced with L1510, THKAO, supine stander, requires prior authorization.
Y6049, swivel walker is replaced with L1520, THKAO, swivel walker, requires prior authorization.
Y6120, Hip guides is replaced with E0956, Wheelchair accessory, Lateral trunk or hip support, prefabricated, including fixed mounting hardware, each (hip guides). Requires prior authorization.
Y6130, Abductor pad, is replaced with E0957, Wheelchair accessory, medial thigh support, prefabricated, including fixed mounting hardware, each (abductor pad). Requires prior authorization.
Y6144, Multi-chamber, air pocket, ROHO cushion is replaced with E0190, Positioning cushion/pillow/wedge, any shape or size, prior authorization required.
Y6045, Prone stander is replaced with L1510, THAKO, suppine stander requires prior authorization
Y6049, Swivel walker and Y6048, Sm swivel walker are replace with L1520, THAKO, swivel walker requires prior authorization

HCPCs Discontinued Codes with replacements effective January 1, 2004.

A4214, Sterile water or saline, 30 cc vial is replaced with A4216, Sterile water/saline, 10 ml.
A4219, Sterile water, irrigation, 1000ml is replace with A4217, Sterile water/saline, 500 ml
A6422, A6424, A6426, A6428, conforming bandages are replaced with A6443, A6444, A6445, A6446, conforming bandage various sizes
S8470, Positioning device, stander for use by patient who is unable to stand independently.
Is replaced with E0638, same descriptor, limited to ages 2-20, requires prior authorization
K0549, Hospital bed, heavy duty, extra wide, greater than 350 lbs but less than 600 lbs is replaced with E0303, same descriptor, rental or purchase, requires prior authorization.
K0531RR, Humidifier, heated, used with positive airway pressure device is replaced with
E0562RR, Humidifier, heated, used with positive airway pressure device
K0532RR, Respiratory assist device, bi-level w/o backup rate monitoring (BPAP-S) is replace by E0470RR, Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface. Requires prior authorization
K0533RR, Respiratory assist device, bi-level pressure capability, with backup rate feature, used with noninvasive interface.
E0471RR, Respiratory assist device, bi-level pressure capability, with backup rate feature, used with noninvasive interface. Requires prior authorization.
K0083 22 NF sealed lead acid battery, each (e.g., gel cell, absorbed glass mat) is replaced with E2360, 22 NF non-sealed lead acid battery and Power wheel chair Accessory: group 24 non-sealed lead acid battery, each, requires prior authorization.
K0085 Group 24 sealed lead acid battery, each (e.g., gel cell absorbed glass mat) is replaced with
E2361 22 NF sealed lead acid battery, each (e.g., gel cell, absorbed glass mat) and
E2363 Power wheel chair Accessory: group 24 sealed lead acid battery, each (e.g. gel cell, absorbed glass mat), requires prior authorization.
K0591, Ostomy Pouch, urinary, with extended wear barrier attached, with facet-type tap with valve, each is replaced by
A4428, Ostomy Pouch, urinary, with extended wear barrier attached, with facet-type tap with valve, one piece each
A4621, Tracheotomy mask or collar is replaced with A7525, Tracheostomy mask, each and
A7526 Tracheostomy tube collar/holder , each
A4622 Tracheostomy or laryngectomy tube is replaced with A7520, Tracheostomy/Laryngectomy tube, non-cuffed, PVC, silicone, or equal, each and A7521, Tracheostomy/Laryngectomy tube, cuffed, PVC, silicone, or equal, each

Discontinued Codes

L0400, TLSO, anterior-posterior-lateral control molded to patient model, with interface material
K0048, Elevating foot rest extension tubes
K0080, Anti roll back device
Y6000, Air fluidation bed
Y0662, Customized wheelchair, pediatric design, fitting and assembly fee

Y0665, Customized wheelchair, adult design, fitting and assembly fee
Y6046, Position support bath system
Y6133, Gel positioning cushion system, with attachments
K0460, Power add-on, to convert manual wheelchair to motorized wheelchair, joystick control
K0461, Power add-on to convert manual wheelchair to motorized wheelchair, tiller control.

Additional Discontinued Codes

A4631	E0976
A6430	E0979
A6434	K0025
E0145	K0268

HCPCS 2004 Long Description Change, Medical Supply Codes

A4326	E0950	E0967	E0978	L2405
A4623	E0951	E0972	E0990	L4350
E0141	E0952	E0973	E0995	L5984
E0143	E0961	E0974	E1390	L6675
E0149	E0966			

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04 - 08 Non-Sedating Antihistamines Restricted

Zyrtec (cetirizine), Allegra (fexofenadine), and Clarinex (desloratadine) formulations require a prior approval effective January 1, 2004.

OTC loratadine and OTC loratadine-D formulations (brand and generic) covered without a prior approval. Clients must have documented allergy to loratadine or failure on loratadine within the last 90 days before access to cetirizine, fexofenadine or desloratadine. Zyrtec syrup for age 0-10 does not require a prior approval. Non-sedating antihistamines limited to 30 doses/30 days. Older sedating antihistamines are not affected by this policy. ☐

04 - 09 2004 ICD.9CM Codes

The 2004 ICD.9.CM codes have been reviewed and evaluated.

The following invalid ICD.9 diagnosis codes have been closed in the Reference File:
255.1, 277.8, 282.4, 289.8, 331.1, 348.3, 358.0, 458.2, 530.2, 600.0, 600.1, 600.2, 600.9, 719.70, 719.75, 719.76, 719.77, 719.78, 719.79, 752.8, 766.2, 767.1, 790.2, 799.8, 850.1, 959.1, V04.8, V43.2, V53.9, V54.0, V64.4, V65.1.

The following diagnosis code titles have been revised:
282.60, 282.61, 282.62, 282.63, 282.69, 414.06, 491.20, 491.21, 493.00, 493.02, 493.10, 493.12, 493.20, 493.22, 493.90, V06.1, V06.5 .

The following ICD.9 Surgical Procedure Code Titles have been revised:
37.33 Excision or destruction of other lesion or tissue of heart, open approach
37.34 Excision or destruction of other lesion or tissue of heart, other approach
39.79 Other endovascular repair (of aneurysm) of other vessels

The following ICD.9 Surgical Procedure Codes are invalid for billing and are removed from the Medical and Surgical Procedures List and closed in the Reference File:

37.5 Heart replacement procedures – Associated with CPT Code 33945
68.3 Subtotal abdominal hysterectomy – Associated with CPT Code 58180

Appropriate ICD.9 diagnosis codes have been added to the Reference File, the Medical and Surgical Procedures (prior authorization) List, and the Authorized Diagnosis for Emergency Department Services List. .

The following ICD.9 Surgical Procedure Codes are new codes added to the Medical and Surgical Procedures List and the Reference File:

37.51 Heart Transplant, with or without recipient cardiectomy – Associated with CPT Code 33945
68.39 Other subtotal abdominal hysterectomy, NOS – (supracervical hysterectomy) – associated with CPT Code 58180
68.31 Laparoscopic supracervical hysterectomy – Listed with CPT Code 58180 since there is no code specific for the laparoscopic procedure.

The following ICD.9 Surgical Procedure Codes are added the Medical and surgical Procedures List and the Reference File and associated with the four groups of CPT codes listed below:

81.62 Fusion or refusion of 2-3 vertebrae –
81.63 Fusion or refusion of 4-8 vertebrae –
81.64 Fusion or refusion of 9 or more vertebrae –

22548

22585 add on code for 22554, 22556, and 22558

22614 add on code for 22600, 22610, and 22612

22632 add on code for 22630

The following ICD.9 Surgical Procedure Codes are Non-covered:

37.52 Implantation of total replacement heart system (Artificial Heart). Associated with CPT Code 0051T
37.53 Replacement or repair of thoracic unit of total replacement hart system. Associated with CPT Code 0052T
37.54 Replacement or repair of other implantable component of total replacement heart system. Associated with CPT code 0053T

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04 - 10 CPT Codes: Assistant Surgeon, Physician Services

Codes NOT Authorized for an Assistant Surgeon

The list Codes NOT Authorized for An Assistant Surgeon in the Utah Medicaid Provider Manual for Physician Services has been updated as a result of HCPCS 2004. (Codes on this list are generally covered by Medicaid but NOT covered for an assistant surgeon.) Discontinued codes are removed, and new codes are added. Providers of physician services will find a new list attached.

The following codes are covered, but NOT for an assistant surgeon. They are added to the list Codes NOT Authorized for An Assistant Surgeon.

31632	36568	36583	53500	76937
31633	36569	36584	57425	84156
36555	36570	36585	63101	84157
36556	36571	36589	63102	85055
36557	36575	36590	64681	87660
36558	36576	36597	70557	89225
36560	36578	36838	70558	89230
36563	36580	43237	70559	89235
36565	36581	43238	75998	89240
36566	36582			

Codes Discontinued

The CPT codes which follow are removed from the Assistant Surgeon list because they are discontinued: 36488, 36489, 36490, 36491, 76085, 76490.

Physician Services, Non-Covered Codes now Discontinued by HCPCS 2004

The CPT codes listed below have not been covered by Medicaid. They were on the MEDICAL AND SURGICAL PROCEDURES "CPT Code" List as "NOT A BENEFIT". Now they are discontinued by HCPCS 2004, so they are removed from the list. Descriptors are abbreviated.

36530 Insertion of implantable intravenous infusion pump
36531 Revision of implantable intravenous infusion pump
36532 Removal of implantable intravenous infusion pump
36536 Mechanical removal of pericatheter obstructive material from central venous device . . .
36537 Mechanical removal of intraluminal obstructive material from central venous device . . .
61862 Twists drill, burr hole, craniotomy, . . .
76085 Digitization of film radiographic images with computer analysis for lesion detection . . .
89252 Assisted oocyte fertilization, microtechnique
89256 Preparation of cryopreserved embryos for transfer
99551 Home infusion for pain management (intravenous or subcutaneous), per visit
99552 Home infusion for pain management (epidural or intrathecal), per visit
99553 Home infusion for tocolytic therapy, per visit
99554 Home infusion for hematopoietic hormones . . .
99555 Home infusion for chemotherapy , per visit
99556 Home infusion for antibiotics/antifungal/antiviral, per visit
99557 Home infusion for continuous anticoagulant therapy, per visit
99558 Home infusion for immunotherapy, per visit
99559 Home infusion of peritoneal dialysis, per visit
99560 Home infusion of enteral nutrition, per visit
99561 Home infusion of hydration therapy, per visit
99562 Home infusion of total parenteral therapy, . . .
99563 Home infusion of aerosolized pentamidine, . . .
99564 Home infusion of anti-hemophilic agents, . . .
99565 Home infusion of alpha-1 proteinase inhibitor, per visit
99566 Home infusion of uninterrupted, long term intravenous treatment, per visit
99567 Home infusion of sympathomimetic agents . . .
99568 Home infusion of miscellaneous drugs, per visit
99569 Home infusion, each additional therapy . . .

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04 - 11 Code Correction

ICD.9.CM Surgical Procedure Code 65.25 has been inappropriately associated on the Prior Authorization List with oophorectomy procedure 58940, requiring a prior authorization. The appropriate relationship of procedure code 65.25 is to excision or destruction of ovarian lesion or tissue, 58662 and 58925, with no prior authorization necessary. The correction has been made. ☐

04 - 12 Attention: Mental Health Centers

Corrections have been made to the Utah Medicaid Provider Manual for Mental Health Centers and to the Utah Medicaid Provider Manual-Targeted Case Management for the Chronically Mentally Ill Provider Manual.

Mental health centers will find attached an updated page 7 for the Utah Medicaid Provider Manual for Mental Health Centers and an updated page 3 for the Utah Medicaid Provider Manual-Targeted Case Management for the Chronically Mentally Ill Provider Manual. A vertical line in the margin is next to the text that has been changed.

Contact Merrila Erickson at 538-6501 or merickson@utah.gov if you have questions. ☐

04 - 13 Attention: Mental Health Centers, Substance Abuse Treatment Providers, Licensed Psychologists and DHS Enhancement Providers providing services to subsidized adoptive children exempted from the Prepaid Mental Health Plan

As you are aware, new standardized procedure codes took effect for services provided on or after 10/1/03. Many of the new codes are CPT-4 codes with time increments included in the code definitions. Time units for other codes include 15-minute units and one-hour units. Please refer to Section Two of your applicable Medicaid provider manual for further information about service definitions and time units.

Questions have been raised regarding billing or reporting services when the same service is provided more than once on the same day (e.g., individual therapy in the morning and afternoon). In instances where a service is provided more than once on the same date, use the following billing or reporting procedures:

1. Fee-for-Service Claims - Billing Procedures

   a. Bill the service on separate lines of the same claim specifying the appropriate number of units per line; or

   b. total the number of units and report the service only once on one line of the claim (e.g., 2 units of 90804)

   Please note that if the service provided more than once on the same date is billed on different claims, the Medicaid claims payment system will deny payment of the service on the second claim, interpreting this as a duplicate claim.

2. Prepaid Mental Health Plan contractors only– Encounter Data

   For encounter data, service reporting depends on whether the same or different providers delivered the service.

   a. **Same provider–** If the same provider delivered the service more than once on the same day, the procedures outlined in #1 above apply.

   b. **Different providers, different provider numbers–** If different providers delivered the same service on the same day, and each provider has a unique provider number, report each provider's service separately on separate encounter records.

   c. **Different providers, same generic provider number–** If the providers do not have unique provider numbers, and therefore, the center has assigned the same generic provider number to both providers, the services may be reported following the procedures outlined under #1 above.

If you have any questions, contact Karen Ford at 538-6637. ☐

04 - 14 CPT Code Changes

Editorial Note: Effective January 1, 2004 with new CPT code changes unspecified laboratory codes which will no longer be accepted when there is a specific test available. The specific test must be ordered for reimbursement. Examples of this policy include:

a. The code 87660–Trichomonas vaginalis, direct probe, must be used; the code 87797–Infectious agent not otherwise specified; direct probe technique will no longer be accepted when the test completed is Trichomonas vaginalis, direct probe. This change also applies to the Affirm Test.
b. The code 87800–Infectious agent detection, direct probe technique will no longer be accepted when the test is Chlamydia trachomatis, direct probe. The code 87490--Chlamydia trachomatis, direct probe must be used.

CPT Codes Covered (some descriptors abbreviated)

01173 Anesthesia for open repair of fracture disruption of pelvis or column fracture involving acetabulum
22532 arthrodesis,lateral extracavity technique, including minimal diskectomy to prepare interspace (without decompression) thoracic

22533 arthrodesis,lateral extracavity technique, including minimal diskectomy to prepare interspace (without decompression) lumbar
22534 arthrodesis, lateral extracavity technique, including minimal diskectomy to prepare interspace (without decompression) thoracic or lumbar each additional
31632 Bronchoscopy (rigid or flexible; with or without fluoroscopic guidance) transbronchial biopsy, each additional lobe
31633 Bronchoscopy (rigid or flexible; with or without fluoroscopic guidance) transbronchial needle aspiration biopsy, each additional lobe
35510 Bypassgraft with vein; carotid-brachial
35512 Bypassgraft with vein; subclavian-brachial
35522 Bypassgraft with vein; axillary-brachial
35525 Bypassgraft with vein; brachial-brachial
36555 Insertion of non-tunneled central venous catheter; under 5 years of age
36556 Insertion of non-tunneled central venous catheter; 5 years of age and older
36557 Insertion of tunneled central venous catheter without subcutaneous port or pump; under age 5
36558 Insertion of tunneled central venous catheter without subcutaneous port or pump; age 5 or older
36560 Insertion of tunneled central venous access device with subcutaneous port; under age 5
36561 Insertion of tunneled central venous access device with subcutaneous port; age 5 or older
36563 Insertion of tunneled central venous access device with subcutaneous pump
36565 Insertion of tunneled central venous access device requiring two catheters by two separate venous access sites; without subcutaneous port or pump (i.e. tesio type catheter).
36566 Insertion of tunneled central venous access device requiring two catheters by two separate venous access sites; with subcutaneous port(s)
36568 Insertion of peripheral central venous catheter (PICC)requiring two catheters by two separate venous access sites; without subcutaneous port or pump; under 5 years of age
36569 Insertion of peripheral central venous catheter (PICC)requiring two catheters by two separate venous access sites; without subcutaneous port or pump; 5 years of age and older
36570 Insertion of peripheral central venous access device; with subcutaneous port; under 5 years of age
36571 Insertion of peripheral central venous access device; with subcutaneous port; 5 years of age and older
36575 Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump . . .
36576 Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site
36578 Replacement of catheter only, central venous access device, with subcutaneous port or pump, . . .
36580 Replacement, complete, of a non-tunneled centrally inserted central venous catheter central, without . . .
36581 Replacement, complete, of a tunneled centrally inserted central venous catheter central, without . . .
36582 Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous . . .
36583 Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous . . .
36584 Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous . . .
36585 Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, . . .
36589 Removal of tunneled central venous catheter, without subcutaneous port or pump
36590 Removal of tunneled central venous access device, with subcutaneous port or pump, central or . . .
36597 Repositioning of previously placed central venous catheter under fluoroscopic guidance
36838 Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)
43237 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum . . .
43238 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum . . .
53500 Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (i.e. post surgical obstruction, scarring)
57425 Laparoscopy, surgical, colpopexy (suspension of vaginal apex)
61537 craniotomy with elevation of bone flap for lobectomy, temporal lobe without electrocorticography during surgery
61540 craniotomy with elevation of bone flap; for lobectomy, other than temporal lobe, partial or total, . . .
61566 craniotomy with elevation of bone flap, for selective amygdalohippocampectomy (this surgery used for epilepsy and proven effective in the majority of cases)
61567 craniotomy with elevation of bone flap; for multiple subpial transections, with electrocorticography during surgery.
62160 endoscopic intracranial placement of a ventricular catheter
63101 Vertebral corpectomy (vertebral body resection) partial or complete, lateral extracavity approach . . .
63102 Vertebral corpectomy (vertebral body resection) partial or complete, lateral extracavity approach . . .
70557 MRI (i.e. proton) brain (including brain stem and skull base), during open intracranial procedure (i.e. to assess for residual tumor or residual vascular malformation), without contrast material
70558 MRI (i.e. proton) brain (including brain stem and skull base), during open intracranial procedure (i.e. to assess for residual tumor or residual vascular malformation), with contrast material
70559 MRI (i.e. proton) brain (including brain stem and skull base), during open intracranial procedure (i.e. to assess for residual tumor or residual vascular malformation), without contrast material followed by contrast and . . .
75998 fluoroscopic guidance for central venous access device placement or replacement (catheter only or complete) or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast

injections through access site or catheter with related venography radiologic supervision and interpretation and radiographic documentation of final catheter position (list separately in addition to primary code procedure)

76937 Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (list separately in addition to code for primary procedure)

84156* Protein total, except by refractometry, urine

84157* Protein total, except by refractometry, other source (i.e. synovial fluid, cerebrospinal fluid)

85055 Reticulated platelet assay (used in HIV and thrombocytopenia evaluation)

87660 Infectious agent antigen detection (DNA or RNA); trichomonas vaginalis

89225* Starch granules, feces (replaces discontinued code 89355)

89230* Sweat collection by inotophoresis (replaces discontinued code 89360)

89235* Water load test (replaces discontinued code 89365)

CPT codes Non-covered

0045T Whole body integumentary photography, at request of a physician, for monitoring of high-risk patients; . . .

0046T Catheter lavage of mammary duct(s) for collection of cytology specimen(s), high risk individuals (Gail risk scoring or prior personal history of breast cancer), each breast; single duct

0047T Catheter lavage of mammary duct(s) for collection of cytology specimen(s), high risk individuals (Gail risk scoring or prior personal history of breast cancer), each breast; each additional duct

0048T Implantation of ventricular assist device, extracorporeal, percutaneous transseptal access, single or dual . . .

0049T Prolonged extracorporeal percutaneous transseptal ventricular assist device, greater than 24 hours, each subsequent 24 hour period (List separately in addition to code for primary procedure) (Use code 0049T in conjunction with code 0048T)

0050T Removal of ventricular assist device, extracorporeal, percutaneous transseptal access, single or dual cannulation

0051T Implantation of total replacement heart system (artificial heart) with recipient cardiectomy (For implantation of heart assist or ventricular assist device, see 33975, 33976)

0052T Replacement or repair of thoracic unit of a total replacement heart system (artificial heart) (For replacement or repair of other implantable components in a total replacement heart system (artificial heart), use 0053T)

0053T Replacement or repair of implantable component or components of a total replacement heart system (artificial heart) excluding thoracic unit (For replacement or repair of a thoracic unit of a total replacement heart system (artificial heart), use 0052T)

0054T Computer assisted musculoskeletal surgical navigational orthopedic procedure with image-guidance based on fluroscopic images (list separately in addition to code for primary procedure)

0055T Computer assisted musculoskeletal surgical navigational orthopedic procedure with image-guidance based on CT and MRI images (list separately in addition to code for primary procedure)

0056T Computer assisted musculoskeletal surgical navigational orthopedic procedure, image-less (list separately in addition to codes for primary procedure)

0057T Upper gastrointestinal endoscopy, including esophagus, stomach and either the duodenum and/or jejunum as appropriate, with delivery of thermal energy to the muscle of the lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease.

0058T cryopreservation; preproductive tissue, ovarian

0059T oocyte(s)

0060T electrical impedance scan of the breast, bilateral (risk assessment device for breast cancer)

0061T Destruction/reduction of malignant breast tumor including breast carcinoma cells in the margins, microwave phased array thermotherapy,disposable catheter with combined temperature monitoring probe and microwave sensor, externally applied microvave energy, including interstitial placement of sensor

00529 Anesthesia for closed chest procedures, mediatinoscopy and diagnostic thorascopy utilizing one lung ventilation

01958 Anesthesia for external cephalic version procedure

20982 Radiofrequency ablation of bone tumor (osteoid osteoma, metastasis)

21685 Hyoid myotomy and suspension

34805 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection using aorto-uniiiliac or aorto- . . .

36595 Mechanical removal of pericatheter obstructive material (i.e. fibrin sheath) from central venous access . . .

36596 Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through . . .

37765 Stab phlebotomy for varicose veins, one extremity; 10-20 stab incisions

37766 Stab phlebotomy for varicose veins, one extremity; more than 20 incisions

47140 Donor hepatectomy, with preparation and maintenance of allograft from living donor; left lateral segment only (segments II and III)

47141 Donor hepatectomy, with preparation and maintenance of allograft from living donor; total left lobectomy (segments II, III, and IV)

47142 Donor hepatectomy, with preparation and maintenance of allograft from living donor; total right lobectomy

(segments V, VI, VII, and VIII)
59070 Transabdominal amnioinfusion, including ultrasound guidance
59072 Fetal umbilical cord occulsion, including ultrasound guidance
59074 Fetal fluid drainage
59076 Fetal shunt placement, including ultrasound guidance
59897 Unlisted fetal invasive procedure, including ultrasound guidance
64449 Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)
64517 Injection anesthetic agent, superior hypogastric plexus (used in chronic pain for stomach or pelvic cancers)
65781 Ocular surface reconstruction; limbal stem cell allograft (i.e. living donor or cadaver) includes obtaining graft
65782 Ocular surface reconstruction; limbal conjunctival autograft (includes obtaining graft)
67912 Correction of lagophthalmos, with implantation of upper eyelid lid load (i.e. gold weight)
68371 Harvesting conjuctival allograft, living donor
76082 Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure
76083 Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)
76514 Ophthalmic ultrasound, echography, diagnostic, corneal pachymetry unilateral or bilateral (determination of corneal thickness)
76940 Ultrasound guidance for and monitoring of , visceral tissue ablation
78804 Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent (whole body), . . .
79403 Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion
89220 sputum, obtaining specimen, aerosol induced technique (separate procedure)
89268 Insemination of oocytes
89272 Extended culture of oozyte(s)/embryo(s), 4-7 days
89280 Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes
89281 Assisted oocyte fertilization, microtechnique; greater than 10 oocytes
89290 Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos
89291 Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos
89335 cryopreservation, reproductive tissue, testicular
89342 storage, (per year); embryo(s)
89343 storage, (per year);sperm/semen
89344 storage, (per year); reproductive tissue; testicular/ovarian
89346 storage, (per year); oocyte
89352 thawing of cryopreserved; embryo(s)
89353 thawing of cryopreserved; sperm/semen, each aliquot
89354 thawing of cryopreserved; reproductive tissue, testicular/ovarian
89356 thawing of cryopreserved; oocytes, each aliquot
91110 Gastrointestinal tract imaging, intraluminal (i.e. capsule endoscopy), esophagus through ileum, with physician interpretation and report
95991 Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by physician
97755 Assistive technology assessment (i.e. to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes.

CPT Codes Requiring Documentation with Claim

62161 Neuroendoscopy, intracranial; for dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts (including placement, replacement, or removal of ventricular catheter)
64681 Destruction by neurolytic agent, superior hypogastric plexus, with or without radiological monitoring
89240 Unlisted miscellaneous pathology test

When billing **prolonged physician visit** code 99355 and code 99354 or **prolonged** physician inpatient visit code 99358 and code 99359, supportive documentation must be submitted for review. Documentation must include the time and specifics of service provided over and above the new or established office visit code. Documentation must support significant additional service above the evaluation and management service or the claim will be denied. ☐

04 - 15 New Criteria or Changes to Existing Criteria

Criteria 32A# Vagal Neurostimulator (VNS) Revised (John Hylen, MD)

Prior authorization is required for the implantation of the vagal neurostimulator. Written documentation must be submitted for review by the nurse coordinator. Based on the patient's age the Utilization Review Committee or the Child Health Evaluation and Care Committee will make the determination as to whether the procedure meets Utah Medicaid Criteria for approval. For prior authorization approval of the VNS the patient must meet all of the following criteria:

- A comprehensive examination, evaluation, and recommendations must be completed by an epileptologist who is board-certified or board-eligible in neurology and has completed at least one year of fellowship in epileptology or who is board-certified or board-eligible in pediatric neurology. The epileptologist must document the medical necessity of the procedure of implantation of the vagal nerve stimulation device by submitting the following documentation:
- The patient's seizures must be medically refractory to treatment by anti-epileptic medications. Administration of at least three anti-epileptic medication must be documented in maximal tolerated doses, as determined by drug dosage, the number of doses given each day, and appropriate serum levels of the anti-epileptic medications.
- During the last four months, the patient must have experienced at least four seizures each month.
- All of the patient's EEG and other available neurodiagnostic study reports must be submitted.
- The patient must be documented not to be a candidate for epileptic brain surgery.
- The epileptologist evaluation of the patient must document that behavior aberrations and nonepileptic seizures have been ruled out.
- The VNS implantation procedure must be performed by a board-certified or board eligible surgeon who has completed additional training specifically in the implantation of the VNS device. ☐

04 - 16 Discontinued Injectable Medications Codes

The following codes are discontinued by HCPCS 2004 and will be removed from the Medicaid Injectable Medications list in the Physician Manual. Descriptors are abbreviated in the list below.

J0151 Adenosine, 90 Mg
J1910 Kutapressin, up to 2 Ml
J2000 Lidocaine Hcl, 50 Cc
J2000 Xylocaine Hcl, 50 Ml
J2000 Nervocaine, up to 50 Ml.
J2000 Procaine Hcl, 50 Ml
J2000 Lidocaine Hcl, 50 Ml.
J2352 Octreotide Acetate, 1 Mg
J9180 Epirubicin Hydrochloride, 50 Mg
Q2010 Glatiramer Acetate

☐

04 - 17 CHEC: HIPAA Related Code Changes - Correction

Our October 2003 MIB incorrectly advised providers regarding allowable CPT codes for billing blood lead specimen collection services provided on or after October 1, 2003. Our instructions should have read:

The Child Health Evaluation and Care Medicaid Provider Manual SECTION 2 is being revised as follows:

> In SECTION 2, Chapter 2 - 5, item 5. F (Page10) *Codes for blood lead level test,* we have deleted the instruction beginning with "CHEC providers may...." and ending with "children up to age 2". The instruction now reads: "***CHEC providers may use CPT code 36415 when submitting claims for venipuncture blood lead specimen collection for CHEC eligibles. Capillary blood specimen collection for blood lead testing may be billed using CPT code 36416, but only for CHEC eligibles ages 0 to 24 months.***

If you have questions regarding these changes, please contact Marilyn Haynes-Brokopp at (801)538-6206. ☐

04 - 18 Home Health Update

Several inquiries have been received regarding the recent changes in home health coding and payment. In response, this statement is provided. The home health program had major changes with HIPAA requirements, and the necessary code crosswalks to eliminate the "Y" codes and implement use of standard code sets. Time units are now 15 minutes, hourly or daily. The change and redefinition of codes by HIPPA to more closely define and document a service and the time spent providing the service has also created some changes in the amount of some payments. Where a standard visit was previously indicated as 2 hours, the new definitions are in smaller increments with an established maximum. The Utilization Management staff has an increased responsibility to evaluate the requests, determine the necessary amount of time based on the plan of care, the severity of illness and intensity of service, and process the prior approval accordingly. In a few cases that will not provide the payment previously received for a minimal service.

Chapter 6 of the Home Health Manual has been updated to add a code for skilled nursing services in the home on the 15 minute increment basis to provide such limited service as pre-filling of syringes or filling medication boxes. Since there are no unassigned codes to use, code G0154 is reassigned to this service. Antepartum/postpartum home visits which meet regular Medicaid criteria (not enhanced services) will be reassigned to T1030. In addition, criteria for coverage of physical therapy and speech which were reinstated July 1, have been updated. Occupational therapy is not a benefit for home health services and is so indicated in the grid. The policy for the Long Term Care capitated program has been removed because the program has been moved to the Long Term Care Unit. The pages to update your home health manual are attached. ☐

04 - 19 Education and Training Related to Surgical Procedures

Payments for surgical procedures under Medicaid are global payments that include all pre-operative and post-operative education and training related to the surgery. Associated education and training cannot be billed to either the Medicaid program or the Medicaid patient separately. Billing for these services is prohibited under Section 1 subsection 11-3(C) of the Medicaid Physician Provider Manual. The physician Manual has been updated under Covered Services, #4. The page to update your Manual is attached. ☐

04 - 20 EMERGENCY ONLY SERVICES for Pregnant Women

The Social Security Act § 1903(v) and 42 CFR 440.255(c) address limitations on service to undocumented pregnant women eligible only for emergency services. Effective immediately, some changes have been made and new edits placed in the Medicaid system to allow payment for some selected services without prepayment review. As a reminder, the criteria for covering "Emergency Only Services" are:

1. The condition manifests itself by sudden onset.
2. The condition manifests itself by acute symptoms (including severe pain).
3. The condition requires immediate medical attention.
   A. Immediate medical attention will require attention within 24 hours of the onset of symptoms or within 24 hours of diagnosis which ever comes earlier (no delay for scheduled or convenient time for service).
4. The condition requires acute care, and is not chronic (Does no include any chemotherapy or follow-up care).
5. Coverage will only be allowed until the condition is stabilized sufficient that the patient can leave the acute care facility, or no longer needs constant attention from a medical professional.
6. The condition is not related to an organ transplant procedure.
7. Prenatal or postpartum care are not covered.

Some selected conditions are representative of those in the prenatal period which meet the intent of the act, require "immediate medical attention", and if coded appropriately warrant payment without prior review. Records may still be subject to review if pulled in the mandated monthly sample or targeted for a focused review. Detailed information can be found in the physician manual, Section 2, page 29 and in the Hospital Manual, Section 2, Page 15 item #5. Pages to update your manual are attached. ☐

04 - 21 Physician Assistant Update

The limitation that physician assistants are not authorized to provide supervised service in an emergency department except in rural areas as designated by Medicaid or in federally designated health professional shortage areas is removed from the physician manual Section2, chapter 1-7 item #3. Removing this limitation, does not remove the prohibition on direct billing or payment for the services provided. The manual page is included to update your physician provider manual. ☐

04 - 22 Birthing Center Code Established

The facility charge code for a freestanding birthing center has been established and can be used immediately. The code is 59899 - Unlisted procedure maternity care and delivery. This code is limited only to use by a freestanding birthing center for the facility charge. The Certified, Registered Nurse Midwife provider manual has been updated at Section 2, page 11. ☐

04 - 23 Anesthesia - Post Operative Pain Management Code Change

Effective January 1, 2004, the code 01997 for post operative Daily Management of Intravenous Patient Controlled Analgesia (PCA) will be discontinued. This change is in compliance with HIPAA coding requirements to use standard code sets. The suggested standard replacement is CPT code 99231 for Subsequent Hospital Care. A change has been made in the Post Operative Pain Management policy in the Physician Manual, Section 3, page 12. Replacement pages are attached to update your manual. ☐

04 - 24 Nurse Practitioner Services Clarified

There is not a current provider manual for nurse practitioner services under Medicaid. In response to recent questions regarding the services of Nurse Practitioners, the following clarification is provided.

Licensed, certified family nurse practitioners and licensed, certified pediatric nurse practitioners are the only nurse practitioners Medicaid has been directed to pay independently. This directive was to assure that there would be adequate access to care for the mandates the federal government was making for pregnant women and children. The Utah Medicaid State Plan Attachment 4.19-B, page 21a outlines payment for nurse practitioners (NP) services in one of two ways under the following limitations:

A. A licensed, certified family or pediatric nurse practitioner employed and working under supervision in a private office, group practice, community health center, or local health department shall have his/her services billed by the supervising provider or the employing entity according to the usual and customary fee schedule of the supervisor or employing entity.

B. A licensed, certified Family or pediatric nurse practitioner working in a private, independent practice, [under provisions of licensure and the State Nurse Practice Act] with no relationship to a group practice or facility employment shall bill for services using his/her own provider number according to his/her usual and customary fee schedule. (Emphasis added for clarity).

There is no mention of hospital service in the State Plan reimbursement section because all other licensed nursing staff, including licensed, certified nurse practitioners employed by a hospital or a hospital based clinic or facility are salaried employees of the hospital. Their services are reimbursed in payments otherwise made to the hospital or in the DRG payment. A nurse practitioner can provide any nursing or hospital service within her licensed scope of practice and within her assigned job description within the employing organization. However, a nurse practitioner, independent, supervised, or hospital employed, can not substitute for a physician in providing subsequent hospital care to patients and have that service billed and paid as a supervised physician service. ☐

04 - 25 Code Added for Certified Nurse Midwives

CPT Code 59409 - Vaginal delivery only (with or without episiotomy and/or forceps) has been added to the codes available to Certified Registered Nurse Midwives (CNM). This code is appropriate for any client who presents to the CNM with no prenatal care, but especially for Emergency ONLY clients who are eligible only for labor and delivery. ☐

This bulletin is available in editions for people with disabilities. Call Medicaid Information: 538-6155 or toll free 1-800-662-9651

On-Line (Internet) Address for Medicaid

The On-Line (Internet) address for Medicaid is http://health.utah.gov/medicaid

If you have a problem finding a Medicaid web page, or Medicaid document on the Internet, it is probably because your browser cannot find the old web site. So start on the new home page: http://health.utah.gov/medicaid, find the page you want, and make a new bookmark on the page with the correct address, or correct the Internet address for your old bookmark.
Your old bookmarks may work for a while. But you really need to fix the Medicaid bookmarks to be sure you are getting the latest information. The old Medicaid Internet address is printed in many Medicaid documents. The old address will be corrected as each document is updated. We apologize for any frustration or confusion this change in address may cause.

Separate Bulletins Issued for Non-Traditional Medicaid Plan and Primary Care Network

The Division of Health Care Financing issues separate bulletins to inform providers of changes in the Non-Traditional Medicaid Plan and the Primary Care Network Program. The bulletins are mailed only to enrolled providers who are affected by information in the bulletins.

The January 2004 NTM bulletin will be issued for the following types of services: Physical Therapy, Occupational Therapy, and Vision Care providers.

The January 2004 PCN bulletin will be issued for the following types of services: Optometrists, Ophthalmologists, Pharmacy, Physician.

All bulletins are available on the Medicaid Provider's web site: http://health.utah.gov/medicaid/provhtml/provider.html

Bulletins are under the headings Medicaid Information Bulletins, Non-Traditional Medicaid Plan, and Primary Care Plan. Contact Medicaid Information if you want a printed NTM or PCN bulletin that is not included with this Medicaid bulletin.